BEFORE THE APPEALS BOARD
FOR THE
KANSAS DIVISION OF WORKERS COMPENSATION

ANDREW B. HENSON Claimant	)	
VS.	)	Docket No. 1,038,989
BELGER CARTAGE SERVICE, INC. Self-Insured Respondent	)	

ORDER

STATEMENT OF THE CASE

Respondent requested review of the July 12, 2011, Award and the July 12, 2011, Order, both entered by Administrative Law Judge Nelsonna Potts Barnes. The Board heard oral argument on October 11, 2011. The Director appointed E. L. Lee Kinch to serve as Appeals Board Member Pro Tem in place of former Board Member Julie A.N. Sample. Jan L. Fisher, of Topeka, Kansas, appeared for claimant. Douglas C. Hobbs, of Wichita, Kansas, appeared for the self-insured respondent.

In the Award entered July 12, 2011, the Administrative Law Judge (ALJ) found that claimant's average weekly wage to April 18, 2009, was $1,231.62. After that date, with the addition of fringe benefits, claimant's average weekly wage was $1,661.22. The ALJ found that the medical report of the court-ordered independent medical examiner, Dr. Michelle Brown, was admissible and could be considered as part of the record. The ALJ also found that claimant suffered a crush injury to his mid-back which resulted in a permanent impairment of function to his thoracic spine. Further, the ALJ found that claimant's subsequent heart attack was a direct result of the work-related injury to claimant's chest. The ALJ found that claimant was permanently, totally disabled and that claimant is entitled to future medical treatment upon proper application to and approval by the Director.

In an Order dated July 12, 2011, the ALJ found that the drug Lansoprazole was an authorized medical expense and ordered respondent to reimburse claimant for the cost of the prescription in the amount of $180.02 and also found that respondent must pay claimant the amount of $25 as a penalty for the past due payment of the prescription bill.

The Board has considered the record and adopted the stipulations listed in the Award. During oral argument to the Board, the parties stipulated to the ALJ's findings concerning claimant's preinjury gross average weekly wage with and without fringe benefits

and the date the items of additional compensation should be included in claimant's average weekly wage.

ISSUES

Respondent requests review of the ALJ's findings regarding the nature and extent of claimant's disability. Further, respondent contends the independent medical examination (IME) report of Dr. Michelle Brown should not be admissible because the report is not neutral, the report and Dr. Brown's opinions are not keyed to the AMA *Guides*,[1] and the opinions in the report are not within the ALJ's assignment. In regard to the nature and extent of claimant's disability, respondent argues that Dr. Michael Farrar's opinions are more credible than those of Dr. Michelle Brown and Dr. Daniel Zimmerman and, therefore, the Board should find that claimant's heart attack was not caused by claimant's work-related chest injury but rather by other factors such as claimant's obesity, smoking history, high cholesterol, diabetes, and undiagnosed hypertension and sleep apnea. Respondent asserts that claimant did not meet his burden of proving he is permanently totally disabled. Further, respondent contends claimant failed to prove he had a ratable impairment to the body as a whole, the aggravation of claimant's preexisting condition was not the cause of his increased disability, and his wage loss was due to his being laid off. Accordingly, respondent argues claimant is not entitled to a work disability. Respondent asks the Board to find claimant has a 5 percent permanent impairment of function as a result of his work-related injuries.

In regard to the ALJ's Order of July 12, 2011, respondent asserts the prescription bill for Lansoprazole was not related to claimant's workplace injury or heart attack but was related to claimant's general health. Accordingly, respondent asks the Board to reverse the Order of the ALJ ordering payment of the prescription bill for Lansoprazole and ordering respondent to pay $25 penalties for past due payment of the bill.

Claimant asks that the Board affirm in full the Award and the July 12, 2011, Order of the ALJ. Claimant asserts that respondent's arguments concerning Dr. Brown's report go to the weight of the evidence and not the admissibility of the report. Claimant further contends there is no evidence that Dr. Brown was biased in her opinions as set out in the report, the report was within the scope of the ALJ's Order directing Dr. Brown to provide an IME report in this case, and there is no evidence that Dr. Brown changed her report after her fee dispute with respondent. Claimant contends he is permanently, totally disabled as a result of his thoracic spine injury and heart attack. In the alternative, claimant asserts he is entitled to an 89 percent work disability even without considering the heart condition, as Dr. Zimmerman found he had a 5 percent permanent partial impairment to

[1] American Medical Association, *Guides to the Evaluation of Permanent Impairment* (4th ed.). All references are based upon the fourth edition of the *Guides* unless otherwise noted.

the whole body for his thoracic spine and also found that claimant had a 77.78 percent task loss based on restrictions related to his thoracic spine only.

In regard to the ALJ's July 12, 2011, Order, claimant contends the ALJ was correct in ordering respondent to reimburse claimant for the prescription for Lansoprazole because it was prescribed by the authorized treating physician for his heart condition and not his general health. Claimant also argues the ALJ was correct in ordering respondent to pay a penalty for non-payment of the bill.

The issues for the Board's review of the Award are:

(1) Is the medical report by Dr. Michelle Brown admissible and a part of the record?

(2) What is the nature and extent of claimant's injury and disability?

(2-a) Was claimant's heart attack, suffered after his work-related accident, causally related to the work-related accident or was it merely coincidental to the accident and therefore not compensable?

(2-b) Is claimant permanently, totally disabled?

(2-c) Is claimant entitled to a work disability?

(2-d) What is claimant's percentage of functional disability?

(3) Is claimant entitled to ongoing future and unauthorized medical?

The issues for the Board's review of the July 12, 2011, Order are:

(4) Was the drug in question related to claimant's workplace injury or to claimant's general health?

(5) Is claimant entitled to a civil penalty for respondent's failure to timely pay for that medical expense?

FINDINGS OF FACT

Claimant began working for respondent in March 1990 as a heavy hauler. On February 4, 2008, he was helping load a printing press that weighed several thousands of pounds. At the same time, a coworker was driving a forklift in order to move an extremely large crate. But the forklift was being driven too fast and the forks hit the pallet, causing the crate to slide into the warehouse in claimant's direction. Claimant said the large crate slammed into him, pushing him up against the printing press and pinning him between the crate and the printing press. Claimant heard cracking and popping in his sternum and felt

his whole chest cave in. He was rendered unconscious. The next he knew, he was outside lying on the ground, and he could not get his breath. He said people were pulling on him to get him up, and he was trying to tell them he had been crushed.

Claimant was somehow loaded into a co-worker's pickup. They were headed to the hospital emergency room but received a call from J.D. Doesken, respondent's Wichita Division Manager, who told them to go instead to OccuMed Clinic. While at OccuMed, claimant was seen by Dr. Ronald Davis. Claimant testified he told Dr. Davis that his whole chest was crushed and he heard everything popping. Claimant denied telling Dr. Davis that he had no difficulty breathing but told him he had problems breathing from the time of the accident. He also had pain with deep inhalation and pain in his chest over his heart. An x-ray was taken of claimant's chest, which showed he had no broken bones. No EKG was taken. Dr. Davis gave claimant some pain medication and put him on light duty with restrictions.

Claimant returned to OccuMed the next morning. He told Dr. Davis his symptoms had not changed and he felt a left lower rib popping in and out of place. After his appointment, he returned to work, still on light duty with restrictions to limit lifting to 10 pounds, limit bending, and no overhead work. He was told to label items in the warehouse. Some of the items to be labeled were over 10 pounds, and claimant believed the work was not within his restrictions. He told the dispatcher he was not feeling well, he could not do the work, and he wanted to go home. The dispatcher told him it was okay to leave. Mr. Doesken said his orders to claimant's supervisor were to have claimant make labels, a job that would have been within claimant's restrictions. He denied that claimant was expected to label the items. He stated he did not hear claimant's supervisor give claimant his instructions and also stated that the rigging room attendant may have been out of the room when claimant went to the room to begin his duties. Claimant may not have known he was going to have help with the labeling.

Claimant saw Dr. Davis again on February 8. He testified he told Dr. Davis that his pain increased when he felt his ribs pop out of place but he believed his chest contusion was improving. Claimant was again given light duty restrictions with a 15-pound lifting restriction, limited bending, and no overhead work; but he did not return to work because he was on vacation leave. However, he testified he did not believe he could lift 15 pounds, saying his whole chest was hurting and swollen.

Claimant called Dr. Davis on February 9, 2008, and again on February 11, 2008, both times complaining of inability to breathe and a swollen chest. Dr. Davis told claimant that the crush injury would take time to heal and prescribed pain and anti-inflammatory medications. Claimant saw Dr. Davis on February 13 and said his symptoms were worse, that he had pressure pain in the middle of his chest and his chest was swollen. Dr. Davis' nurse had difficulty getting his blood pressure. Dr. Davis recommended a CT scan, and claimant went straight from Dr. Davis' office to Andover Hospital for the test. As claimant was leaving after the CT scan, he was caught in the parking lot by an x-ray technician, who

told him to return to the hospital. Claimant was taken to the emergency room, where he was seen by a cardiologist, Dr. Hussam Farhoud, and told he was having a heart attack.

Claimant remained in the hospital from February 13 through February 20, 2008. He underwent surgery and a pacemaker was implanted. A problem was later found, and claimant was hospitalized a second time from February 27 through March 3, 2008. Claimant went back to work on April 7, 2008. He still had a 15-pound lifting restriction, but he was helped by his co-workers. On April 7, 2009, claimant was back in the hospital with chest pain, having had a recurrence of blockage inside his stent. After surgery, he was released from the hospital on April 10, 2009.

In April 2009, claimant was laid off. He has not worked since. He applied for and received unemployment benefits for a year and a half. He looked for work during that time as required but was not offered any employment. Claimant said he has no computer skills, although he took a beginners class once at a local library. Claimant testified that if he tries to lift more than 10 pounds, he feels it in his chest and upper back between his shoulder blades. He can only walk about a quarter of a mile before getting short of breath. He has trouble sleeping because of back and chest pain. He cannot be out in cold weather because it affects his lungs and he has trouble breathing. He does not believe he is capable of working because he gets too fatigued and because of the medications he is on.

Claimant said his father died of a heart attack when he was in his late 70s; claimant has no other family history of heart problems. He testified he has never been told he had high cholesterol. He was diagnosed with diabetes in late 2010 but had not been diagnosed as being diabetic before his heart attack. He had smoked about a pack and a half of cigarettes a day but stopped after the accident and before his heart attack. He is 5'9" and at the time of his heart attack, he weighed around 276. Before his heart attack, he had never been told he had any heart disease. He had not had any chest pain or indication he might have heart problems before the heart attack.

On May 12, 2008, the ALJ issued an Order that a neutral physician be appointed to give an opinion on causation and treatment recommendations. The parties were directed to agree upon a physician to perform the court-ordered IME. The parties agreed on Michelle Brown, M.D., FACC, and the ALJ issued an Order on June 12, 2008, ordering Dr. Brown to perform the IME and to provide her opinions on diagnosis, causation and treatment. Dr. Brown met with claimant on three occasions, the first being July 17, 2008. Dr. Brown reviewed the medical records of Drs. Davis and Farhoud and examined the actual images obtained at the time of claimant's Emergent Cardiac Catheterization performed on February 13 by Dr. Farhoud. She also said she had several consultations with claimant's treating cardiologist, Dr. Farhoud. Dr. Brown made a trip to the Kansas Medical Center to review the original images because she did not believe the disc that had been provided her was of sufficient quality to make a judgment of causation. Dr. Brown reviewed the CT films and saw a dissection of the tissue beginning at the lower aspect of the right coronary artery (RCA) ostium. Partial occlusion of the RCA at its origin was seen

to rapidly develop into a complete RCA occlusion. Dr. Brown stated that the trauma to claimant's chest caused a small tear in his aortic root at the level of the insertion of the RCA.

After reviewing claimant's medical record and heart catheterization cine-angiogram, it was Dr. Brown's medical opinion, stated with 100 percent confidence, that claimant's inferior myocardial infarction was a direct result of an acute dissection at the origin of the RCA sustained as a result of a blunt force crush injury to his chest wall. She opined that claimant's heart attack actually developed more than 24 hours after the crush injury and that chest pain from the crush injury masked symptoms of his heart attack and delayed diagnosis and treatment for 24 to 72 hours. She also opined that the failure to allow claimant to receive a more thorough and proper initial medical evaluation, timely treatment and follow-up was a determination made by respondent's management. She said the lack of proper medical care caused claimant's injuries to be much worse than if they had been more timely discovered and treated.

Dr. Brown also opined that claimant's initial chest trauma caused a significant external hematoma to develop which caused prolonged, severe pain to his upper thorax including his anterior chest and back. She believed that claimant developed damage to his kidneys in that he suffered acute renal failure.

Dr. Brown believed that claimant should continue with the same cardiovascular care that was being provided by Dr. Farhoud. She also believed claimant needed an evaluation to determine if he would benefit from psychological counseling and intervention because of his problems sleeping and coping with his inability to perform job functions he previously performed. He will require treatment with multiple medications. Dr. Brown opined that claimant would be unable to perform at a level greater than a sedentary lifestyle. She did not give an opinion as to claimant's percentage of functional impairment under the AMA *Guides*.

Dr. Brown did not testify in this case and the record does not contain her curriculum vitae. Despite having agreed to the selection of Dr. Brown to perform the IME and having represented to the ALJ that Dr. Brown was an M.D., cardiologist, and FACC (Fellow of the American College of Cardiology)[2] and those credentials having been also contained in Dr. Brown's IME report at page 5, counsel for respondent later asserted to the court that he was "not even sure she's [Dr. Brown] a medical physician."[3] The Board finds that Dr. Brown is a medical doctor and a board certified cardiologist. The meaning of the FACC

[2] Correspondence from claimant's attorney to ALJ dated May 20, 2008 and filed with the Division May 20, 2008; correspondence from claimant's attorney and respondent's attorney dated October 15, 2008 and filed with the Division October 30, 2008.

[3] R.H. Trans. at 9.

designation is contained within the curriculum vitae of Dr. Farrar[4] and in his deposition testimony.[5]

Dr. Daniel Zimmerman is board certified in internal medicine and is a certified independent medical examiner. Although he does cardiac evaluations occasionally, he does not do them on a regular basis. He is a district medical advisor for the U.S. Department of Labor and does cardiac evaluations as part of that process. He evaluated claimant on August 13, 2010, at the request of claimant's attorney.

Dr. Zimmerman reviewed claimant's medical records, took a history from claimant and performed a physical examination. Dr. Zimmerman said the medical records from claimant's hospitalization of February 13 to 20, 2008, showed he had a heart attack that was treated with stenting. A pacemaker was implanted after he went into cardiogenic shock. Claimant was again hospitalized from February 27 through March 3, 2008, because his heart was fibrillating. He was hospitalized a third time from April 7 through April 10, 2009, at which time it was found that one of his original stents had become reclotted so it was opened back up.

Claimant had a secondary diagnosis of ejection fraction of 45 percent. Dr. Zimmerman said claimant's left ventricular ejection fraction should be 55 or 60 percent. Claimant's was 45 percent, which meant his left ventricular pumping pressure was slightly decreased, a symptom of heart failure.

Dr. Zimmerman said an EKG taken by Dr. Farrar showed a moderate to severe left ventricular dysfunction with an ejection fraction of 25 to 30 percent. The lower percentage, according to Dr. Zimmerman, reveals claimant's left ventricular pumping pressure is much more deteriorated compared to what it had been. He would expect continued deterioration in the future. Once the ejection fraction gets below 30 percent, a person is at high risk to be in congestive heart failure. So claimant's exercise tolerance would be expected to be reduced. Claimant told Dr. Zimmerman that he got short of breath with exercise and was unable to run, but he was not waking up with chest pain.

During Dr. Zimmerman's physical examination, he first looked at claimant's thoracic area because claimant had a crush injury to his anterior chest wall and was complaining of pain affecting his thoracic spine. He found that claimant had interspinous tenderness from T4 through T10 and tenderness to palpation over the thoracic paraspinous musculature on the right and left sides. Ranges of motion at the thoracic level were within acceptable limits. An x-ray was taken of claimant's thoracic spine, which showed normal vertebral alignment but osteoarthritic change.

---

[4] Farrar Depo., Ex. 1 at 3.

[5] Farrar Depo. at 5.

Claimant had a regular sinus rhythm without murmur, meaning his heart was beating regularly with no skipped beats and no rapid rates of heart rhythm. Dr. Zimmerman said that in terms of cardiac function, he relied largely on claimant's medical records. Claimant had a history of suffering acute renal failure during the hospitalization from February 13 to 20, 2008. Dr. Zimmerman said there was a relationship between claimant's cardiac problems and the acute renal failure. Dr. Zimmerman's testing showed claimant had mild residuals from the acute renal failure.

After examining claimant, Dr. Zimmerman diagnosed him with a crush injury affecting the chest. He opined that claimant developed an acute myocardial infarction, as well as cardiogenic shock and renal failure, as a consequence of the trauma. Dr. Zimmerman testified that claimant's crush injury damaged the ostium of the coronary artery. The cardiac condition manifested itself nine days later. Dr. Zimmerman acknowledged that Drs. Farrar and Brown had different explanations for claimant's cardiovascular issue. He stated: "I'm not going to sit here and say that I as an internist know more than either one of them."[6]

Using the AMA *Guides*,[7] Dr. Zimmerman rated claimant as follows: For chronic thoracic paraspinous myofascitis with permanent aggravation of thoracic osteorarthritis, 5 percent to the whole body; for impairment due to coronary artery disease, 49 percent to the whole body; for arrhythmias, 29 percent to the whole body; for use of aspirin and Carvedilol, 5 percent to the whole body[8], and for upper urinary tract impairment, 10 percent to the whole body.

The above impairments combined for 72 percent to the whole body using the Combined Values Chart. During his deposition, Dr. Zimmerman withdrew his rating for use of aspirin and Carvedilol, 5 percent to the whole body, because claimant was not on an anticoagulant. Without that impairment rating, claimant's total impairment rating was 70 percent to the whole body.

Dr. Zimmerman said claimant is restricted to lifting 10 pounds on an occasional basis and 5 pounds on a frequent basis. He should avoid frequent flexion of the thoracolumbar spine, bending, stooping, squatting, crawling, kneeling and twisting activities at the thoracolumbar level. Due to claimant's coronary artery disease, congestive heart failure and arrhythmia, he should stop and rest because of fatigue and shortness of breath. Claimant should avoid working at heights, around moving machine, operating heavy machinery, and working with exposures to high humidity or temperature extremes. At his

---

[6] Zimmerman Depo. at 41.

[7] American Medical Association, *Guides to the Evaluation of Permanent Impairment* (4th ed.). All references are based upon the fourth edition of the *Guides* unless otherwise noted.

[8] Dr. Zimmerman later withdrew this 5 percent rating.

deposition, Dr. Zimmerman added a restriction of no captive sitting. Dr. Zimmerman was of the opinion that claimant would not be eligible to obtain a CDL.

Dr. Zimmerman reviewed the task list prepared by Dick Santner. Of the 9 tasks on the list, he opined claimant was unable to perform 8 for an 89 percent task loss. He added that of the 8 tasks claimant is unable to perform, 2 are related solely to claimant's thoracic spine and 5 are related to both claimant's thoracic spine and his cardiac condition. Only one task was lost solely due to claimant's cardiac condition.

Dr. Zimmerman acknowledged claimant was obese and that obesity is a risk factor for cardiac problems, albeit a low-level risk factor compared to others. Cigarette smoking is also a risk factor. He said claimant is also being treated for high cholesterol, another risk factor; his triglycerides were mildly elevated. Claimant is also diabetic.

Dr. Michael Farrar is an adult cardiologist. He is board certified in adult echocardiography and is a Fellow of the American College of Cardiology and the American Society of Echocardiography. He examined claimant on January 14, 2011, at the request of respondent, and took a history from him regarding his chest injury.

Dr. Farrar reviewed claimant's echocardiographs, x-rays and CT from a CD-Rom. He testified the quality of the films on the CD-Rom were of sufficient quality for him to interpret and render an opinion. Dr. Farrar testified that the CT scan taken of claimant on February 13, 2008, did not show any evidence of an aortic dissection. Dr. Farrar stated that claimant's heart attack actually occurred 24 to 36 hours before he went in for the CT scan.

Dr. Farrar found that claimant developed cardiogenic shock and had an acute inferior wall myocardial infarction with right ventricular infarction. He explained that claimant had plaque that ruptured and then occluded the right coronary artery, which compromised the blood flow to the bottom wall of the heart. It also compromised the blood flow to the right ventricle of the heart. Dr. Farrar said that commonly with that sort of a heart attack, people develop cardiogenic shock where the blood pressure is low and there is decreased profusion of organs.

Dr. Farrar said claimant underwent cardiac cathertization which showed he had a 30 percent left anterior descending coronary lesion and a 40 percent circumflex marginal coronary lesion. He said those are mild to moderate blockages of plaque formation. The test also revealed claimant's right coronary artery had a preexisting severe blockage. During claimant's hospitalization, he developed acute renal insufficiency, which Dr. Farrar said caused some mild damage. In October 2010, claimant had some lab work done. His kidney function was essentially normal to minimally abnormal, but it was not significant.

When claimant was seen by Dr. Farrar in January 2011, he complained of being fatigued. Dr. Farrar suspected claimant had undiagnosed sleep apnea. With sleep apnea,

because the person is tired all the time, the heart is bombarded with adrenaline all the time, which will weaken the heart and cause atrial fibrillation. Claimant said he walked but is limited by shortness of breath and by blisters on his foot. Claimant showed no signs of orthopnea, paroxysmal nocturnal dyspnea or edema, which are symptoms of congestive heart failure. Dr. Farrar said smoking is a huge risk factor for a heart attack.

At the physical examination, claimant had mildly high blood pressure. His weight was 284 pounds and his BMI was 42, putting him in the extreme obese category. He had an essentially normal heart examination. He did not have any swelling. Dr. Farrar interrogated his pacemaker with good results. Claimant had no compromised blood supply to the heart and there was no evidence of any significant additional blockages. Claimant had no evidence of inducible ischemia.

Dr. Farrar testified that about a week after claimant's injury, he had a heart attack. Because of claimant's chest pain due to his injury, his heart attack symptoms would have been masked. Dr. Farrar said it would probably be impossible to sort out what was claimant's heart attack and what was his chest injury pain. Dr. Farrar opined that claimant had an unstable plaque in his right coronary artery that ruptured forming a blood clot that completely occluded the artery and then manifested as a heart attack. He said claimant's treatment was appropriate although he was not sure claimant needed a permanent pacemaker versus a temporary pacemaker.

Dr. Farrar disagreed with Dr. Brown's opinion that the claimant's chest wall contusion caused a focal dissection of the right aorta. He said a true traumatic dissection is rare. Most of the time trauma to the aorta causes a transection, where it tears, and not a dissection. Also, he opined it would be a coincidence to have both preexisting severe plaque in the artery and then have a dissection from trauma that caused the heart attack. He said that 99 percent of heart attacks in men of claimant's age are caused by unstable plaque that ruptures in patients who have preexisting risk factors such as dyslipidema, smoking, untreated high blood pressure or untreated sleep apnea. He also said it would be unusual to develop a traumatic dissection and then not have it progress to a heart attack until 8 or 9 days later. Dr. Farrar said if claimant would have had an aortic dissection as opined by Dr. Brown, his symptoms would have manifested themselves much earlier. There would have been some evidence of a coronary dissection at the time the coronary angiography was done. Also, there was no evidence of aortic dissection at the time of the CT scan.

Dr. Farrar believes claimant's atrial fibrillation is multi-factorial. He believed that claimant is prone to atrial fibrillation because of undiagnosed and untreated sleep apnea, underlying hypertension, and the stress of his illness. He believes claimant's acute renal insufficiency was caused by claimant's cardiogenic shock.

Dr. Farrar said claimant has significant left ventricle dysfunction which he related to post-myocardial infarction remodeling. He said if there is an area of heart muscle that is

damaged, the heart will lose its normal geometry. He believes that is the case here because claimant's ejection fraction after the heart attack was only mildly diminished, and now it is significantly diminished. He said that left ventricular dysfunction from sleep apnea is common and diagnosing and treating claimant's sleep apnea would help. Dr. Farrar suspects claimant has sleep apnea but does not know for sure. He did not ask claimant if he had fatigue before his accident.

Dr. Farrar said claimant has some limitations, and the limitations are multi-factorial. He is obese, deconditioned and has left ventricular dysfunction. A preexisting foot injury limits his walking. Dr. Farrar said claimant has Class 2 heart failure, which means mild symptoms of heart failure. He said there are issues with pacemakers, such as when a person with a pacemaker would arc weld or work around high voltage lines.

Dr. Farrar believes some of claimant's medications need to be intensified. He recommends claimant have a sleep study for sleep apnea. Dr. Farrar reviewed a job task list prepared by Steve Benjamin. Of the 13 tasks on the list, Dr. Farrar opined that claimant was unable to perform 5 for a 38 percent task loss. Dr. Farrar said that he sees people with heart conditions similar to claimant's who return to work. Dr. Farrar did not know claimant's educational level. He did not know claimant's past work history, other than he worked for respondent a number of years. Other than claimant drove a truck, he did not know any other skills claimant may have developed or aptitudes claimant may have. He did not know about the geographic area where claimant lives. Dr. Farrar reviewed the task list based only on claimant's heart condition. He did not consider any back injury claimant may have sustained at the time of the accident.

Dick Santner, a vocational rehabilitation counselor, saw claimant on November 30, 2010, at the request of claimant's attorney. He compiled a list of 9 tasks that claimant had performed in the 15 years before his injury.

Claimant told Mr. Santner that he had been trying to find some sort of a driving job since it was about the only thing he still retained the capacity to do from his former job. He has not been able to get a job. Claimant told Mr. Santner he completed the 11th grade in school and went into the military. He obtained his GED while in the military, and later obtained a CDL. Claimant told Mr. Santner he cannot pass the physical for the Department of Transportation anymore, so he cannot use his CDL. Mr. Santner said claimant would be considered a stable employee because of the length of time he worked for respondent. He would be considered a semi-skilled worker. However, claimant has a narrow range of work skills. In considering the restrictions of Dr. Brown, Mr. Santner did not find that claimant would have any transferrable skills. In looking at the restrictions of Dr. Zimmerman, Mr. Santner found that claimant would have only minimal transferrable skills. Mr. Santner said there are sedentary unskilled jobs, but they exist in small numbers. He did not think claimant would be able to pass a pre-employment physical. And even if a pre-employment physical was not required, claimant would be competing with many other people right now in the current labor market. Mr. Santner did not believe claimant would

get a job compared to someone who was healthier, had no medical issues, was younger, and who would be a lower risk for a prospective employer. He did not think claimant had any sedentary work skills, and his medical condition is significant. Realistically, he did not think claimant is employable.

Steve Benjamin, a vocational rehabilitation consultant, met with claimant on February 4, 2011, at the request of respondent. He prepared a list of 13 tasks that claimant performed in the 15-year period before his accident. Claimant told Mr. Benjamin that he had applied for unemployment benefits, which required that claimant agree he was ready, willing and able to return to work. Mr. Benjamin believed that claimant was able to obtain employment. In forming this opinion, he relied upon the restrictions placed on claimant by Drs. Zimmerman and Fevurly.[9] In re-entering the job market, claimant would be looking at an entry-level type job and salary. If claimant were to re-enter the job market, he could earn approximately $317.20 per week.

Mr. Benjamin identified four jobs that claimant could perform. The jobs were such that an individual could sit most of the shift and were entry-level. The job list was not exhaustive but was only a representative list, and included parking lot attendant, order clerk, telephone solicitor and van driver. On cross examination, it was established that claimant could have difficulty performing certain aspects of each of these jobs. Also, it is not known whether any of these jobs are available in claimant's area. Mr. Benjamin stated he believed there was a job opening for a driver with Breakthrough Club of Sedgwick County. He said that particular job did not require a CDL. But Mr. Benjamin acknowledged that claimant would not be able to help handicapped individuals in and out of a van and there would be no way to guarantee that some of the people in the van would not be handicapped. He also acknowledged that claimant probably would be unable to lay down for an hour and rest unless he could break it down into shorter segments of time and incorporate his rests during his regular work breaks.

Claimant told Mr. Benjamin he had applied for 50 jobs between March 2009 and August 2010 and was never offered a position. Mr. Benjamin said that working in job placement, he asks people to make between 5 and 10 contacts a week, in person or telephone, when making a job search. He would not consider claimant's search of 50 employers between March 2009 and August 2010 to be an adequate job search.

Respondent also asks the Board to reverse the ALJ's Order finding it should pay for the prescription bill for Lansoprazole, prescribed for claimant by his treating cardiac physician, Dr. Farhoud. Respondent's expert, Dr. Farrar, testified that because aspirin can irritate the stomach, it is common to use medications such as Lansoprazole to potentially decrease the risk of ulcer. Claimant testified he had no problems with heartburn, ulcers or stomach problems before he suffered the heart attack. It was his understanding he is

[9] Dr. Chris Fevurly did not testify in this case and his report is not part of the record.

taking the medicine as a preventative measure for conditions that could result from taking his other medication.

PRINCIPLES OF LAW

K.S.A. 2010 Supp. 44-501(a) states:

> If in any employment to which the workers compensation act applies, personal injury by accident arising out of and in the course of employment is caused to an employee, the employer shall be liable to pay compensation to the employee in accordance with the provisions of the workers compensation act. In proceedings under the workers compensation act, the burden of proof shall be on the claimant to establish the claimant's right to an award of compensation and to prove the various conditions on which the claimant's right depends.

K.S.A. 2010 Supp. 44-501(e) states:

> Compensation shall not be paid in case of coronary or coronary artery disease or cerebrovascular injury unless it is shown that the exertion of the work necessary to precipitate the disability was more than the employee's usual work in the course of the employee's regular employment.

K.S.A. 2010 Supp. 44-508(g) defines burden of proof as follows: "'Burden of proof' means the burden of a party to persuade the trier of facts by a preponderance of the credible evidence that such party's position on an issue is more probably true than not true on the basis of the whole record."

An employer is liable to pay compensation to an employee where the employee incurs personal injury by accident arising out of and in the course of employment.[10] Whether an accident arises out of and in the course of the worker's employment depends upon the facts peculiar to the particular case.[11]

The two phrases arising "out of" and "in the course of" employment, as used in the Kansas Workers Compensation Act, have separate and distinct meanings; they are conjunctive and each condition must exist before compensation is allowable.

> The phrase "out of" employment points to the cause or origin of the accident and requires some causal connection between the accidental injury and the employment. An injury arises "out of" employment when there is apparent to the rational mind, upon consideration of all the circumstances, a causal connection between the conditions under which the work is required to be performed and the

---

[10] K.S.A. 2010 Supp. 44-501(a).

[11] *Kindel v. Ferco Rental, Inc*., 258 Kan. 272, 278, 899 P.2d 1058 (1995).

> resulting injury. Thus, an injury arises "out of" employment if it arises out of the nature, conditions, obligations, and incidents of the employment. The phrase "in the course of" employment relates to the time, place, and circumstances under which the accident occurred and means the injury happened while the worker was at work in the employer's service.[12]

An accidental injury is compensable under the Workers Compensation Act even where the accident only serves to aggravate a preexisting condition.[13] The test is not whether the accident causes the condition, but whether the accident aggravates or accelerates the condition.[14] An injury is not compensable, however, where the worsening or new injury would have occurred even absent the accidental injury or where the injury is shown to have been produced by an independent intervening cause.[15]

K.S.A. 44-510e(a) states in part:

> Permanent partial general disability exists when the employee is disabled in a manner which is partial in character and permanent in quality and which is not covered by the schedule in K.S.A. 44-510d and amendments thereto. The extent of permanent partial general disability shall be the extent, expressed as a percentage, to which the employee, in the opinion of the physician, has lost the ability to perform the work tasks that the employee performed in any substantial gainful employment during the fifteen-year period preceding the accident, averaged together with the difference between the average weekly wage the worker was earning at the time of the injury and the average weekly wage the worker is earning after the injury. In any event, the extent of permanent partial general disability shall not be less than the percentage of functional impairment. Functional impairment means the extent, expressed as a percentage, of the loss of a portion of the total physiological capabilities of the human body as established by competent medical evidence and based on the fourth edition of the American Medical Association Guides to the Evaluation of Permanent Impairment, if the impairment is contained therein. An employee shall not be entitled to receive permanent partial general disability compensation in excess of the percentage of functional impairment as long as the employee is engaging in any work for wages equal to 90% or more of the average gross weekly wage that the employee was earning at the time of the injury.

---

[12] *Id.* at 278.

[13] *Odell v. Unified School District*, 206 Kan. 752, 758, 481 P.2d 974 (1971).

[14] *Woodward v. Beech Aircraft Corp.*, 24 Kan. App. 2d 510, Syl. ¶ 2, 949 P.2d 1149 (1997).

[15] *Nance v. Harvey County*, 263 Kan. 542, 547-50, 952 P.2d 411 (1997).

In *Tyler*,[16] the Kansas Court of Appeals stated: "Absent a specific statutory provision requiring a nexus between the wage loss and the injury, this court is not to read into the statute such a requirement."

K.S.A. 44-510c(a)(2) defines permanent total disability as follows:

> Permanent total disability exists when the employee, on account of the injury, has been rendered completely and permanently incapable of engaging in any type of substantial and gainful employment. Loss of both eyes, both hands, both arms, both feet, or both legs, or any combination thereof, in the absence of proof to the contrary, shall constitute a permanent total disability. Substantially total paralysis or incurable imbecility or insanity, resulting from injury independent of all other causes, shall constitute permanent total disability. In all other cases permanent total disability shall be determined in accordance with the facts.

While the injury suffered by the claimant was not an injury that raised a statutory presumption of permanent total disability under K.S.A. 44-510c(a)(2), the statute provides that in all other cases permanent total disability shall be determined in accordance with the facts. The determination of the existence, extent and duration of the injured worker's incapacity is left to the trier of fact.[17]

In *Wardlow*[18], the claimant, an ex-truck driver, was physically impaired and lacked transferrable job skills making him essentially unemployable as he was capable of performing only part-time sedentary work.

The court in *Wardlow* looked at all the circumstances surrounding his condition including the serious and permanent nature of the injuries, the extremely limited physical chores he could perform, his lack of training, his being in constant pain and the necessity of constantly changing body positions as being pertinent to the decision whether the claimant was permanently totally disabled.

K.S.A. 2010 Supp. 44-510h(a) states:

> It shall be the duty of the employer to provide the services of a health care provider, and such medical, surgical and hospital treatment, including nursing, medicines, medical and surgical supplies, ambulance, crutches, apparatus and transportation to and from the home of the injured employee to a place outside the

---

[16] *Tyler v. Goodyear Tire & Rubber Co.*, 43 Kan. App. 2d 386, 391, 224 P.3d 1197 (2010). See also *Lewis v. Sun Graphics, Inc.*, 2010 WL 3564802, Kansas Court of Appeals unpublished opinion filed September 3, 2010 (No. 103,277).

[17] *Boyd v. Yellow Freight Systems, Inc.*, 214 Kan. 797, 522 P.2d 395 (1974).

[18] *Wardlow v. ANR Freight Systems*, 19 Kan. App. 2d 110, 113, 872 P.2d 299 (1993).

> community in which such employee resides, and within such community if the director, in the director's discretion, so orders, including transportation expenses computed in accordance with subsection (a) of K.S.A. 44-515 and amendments thereto, as may be reasonably necessary to cure and relieve the employee from the effects of the injury.

K.S.A. 44-515(e) states:

> Any health care provider's opinion, whether the provider is a treating health care provider or is an examining health care provider, regarding a claimant's need for medical treatment, inability to work, prognosis, diagnosis and disability rating shall be considered and given appropriate weight by the trier of fact together with consideration of all other evidence.

K.S.A. 44-516 states:

> In case of a dispute as to the injury, the director, in the director's discretion, or upon request of either party, may employ one or more neutral health care providers, not exceeding three in number, who shall be of good standing and ability. The health care providers shall make such examinations of the injured employee as the director may direct. The report of any such health care provider shall be considered by the administrative law judge in making the final determination.

ANALYSIS AND CONCLUSIONS

Having considered the entire record, the Board finds that the ALJ's Award and Order should both be affirmed. The Board finds ongoing medical treatment should also be awarded but otherwise agrees with and adopts the ALJ's analysis and conclusions.

(1) The medical report by Dr. Michelle Brown is admissible and a part of the record. At the parties request, the ALJ entered an order pursuant to K.S.A. 44-516 that Dr. Brown evaluate claimant and render her expert medical opinions concerning diagnosis, causation and treatment. The doctor issued such a report, and the ALJ properly considered that evidence. That report is a part of the record considered by the Board in this review of the ALJ's Award and Order.

(2) As a direct consequence of the February 4, 2008, accident, claimant suffered crush injuries to his chest, back and internal organs, including a dissection or laceration to his right coronary artery, which led to his subsequent heart attack. These injuries resulted in a 70 percent permanent impairment of function and an inability to engage in substantial, gainful employment. As claimant is realistically unemployable, the issue of his percentage of work disability is moot.

(3) Claimant is entitled to ongoing and future medical treatment and unauthorized medical up to the statutory maximum. Claimant is on medications and has a pacemaker

implanted that requires monitoring and periodic replacement of its battery pack. The expert medical opinion testimony establishes claimant has a need for ongoing treatment for his heart condition.[19] The testimony of claimant and Dr. Zimmerman also show a need for treatment of claimant's chest and back injuries, including palliative care.

(4) Lansoprazole is a drug that is reasonably necessary to cure and relieve the effects of claimant's injuries.[20] It is reasonably expected to reduce the potential negative effects of the necessary aspirin therapy and pain medications. Claimant is entitled to reimbursement for this prescription drug expense

(5) Claimant is entitled to a civil penalty of $25 for respondent's failure to timely pay for the Lansoprazole.

AWARD

WHEREFORE, it is the finding, decision and order of the Board that claimant is also entitled to an award for ongoing medical treatment but that the Award and the Order of Administrative Law Judge Nelsonna Potts Barnes dated July 12, 2011, are otherwise affirmed.

IT IS SO ORDERED.

Dated this _____ day of October, 2011.

_____
BOARD MEMBER

_____
BOARD MEMBER

_____
BOARD MEMBER

c: Jan L. Fisher, Attorney for Claimant
Douglas C. Hobbs, Attorney for the Self-Insured Respondent
Nelsonna Potts Barnes, Administrative Law Judge

[19] See, *e.g.*, Dr. Brown's report (filed Dec. 15, 2009) at 14-15; Farrar Depo. at 24-25, 29, and 35-36.

[20] See, *e.g.*, Farrar Depo. at 25, 42-43.